MEDICAID WAIVER ASSESSMENT

SECTION I – RECIPIENT DEMOGRAPHICS

Name *(last, first, middle)*	Date of birth *(mo., day, yr.)* / /		Medicaid number
Street address	County code	Sex *(check one)* ☐Male ☐Female	Marital status *(check one)* ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed
City, state and zip code	Emergency contact *(name)*		Emergency contact *(phone #)* ( ) -
Recipient phone number ( ) -	Is recipient able to read and write ☐Yes ☐No		Recipient's height Recipient's weight

SECTION II – RECIPIENT WAIVER ELIGIBILITY

Type of program applied for *(check one)* ☐ Home and Community Based Waiver ☐ Model Waiver II ☐ Homecare Waiver ☐ Personal Care Assistance Waiver	Type of application *(check one)* ☐ Certificaton ☐ Re-certification
Recipient admitted from *(check one)* ☐Home ☐Hospital ☐Nursing facility ☐Other	Certification period *(enter dates below)* Begin date / / End date / /
Has recipient's freedom of choice been explained and verified by a signature on the MAP 350 Form ☐Yes ☐No	Has recipient been informed of the process to make a complaint ☐Yes ☐No (*see instructions*)

Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number ( ) -

Enter recipient diagnosis(es): Primary:
Secondary:
Others:

SECTION III – PROVIDER INFORMATION

Provider name	Provider number	Provider phone number ( ) -
Street address	City, state and zip code	
Provider contact person		

SECTION IV – ACTIVITIES OF DAILY LIVING

1) Is recipient independent with **dressing/undressing** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires total assistance	Comments:
2) Is recipient independent with **grooming** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues Requires hands-on assistance with ☐ oral care ☐shaving ☐ nail care ☐hair ☐ Requires total assistance	Comments:

Name *(last, first)* Medicaid Number

3) Is recipient independent with **bed mobility** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Bed-bound	Comments:
4) Is recipient independent with **bathing** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires Peri-Care ☐ Requires total assistance	Comments:
5) Is recipient independent with **toileting** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Bladder incontinence ☐ Bowel incontinence ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Requires total assistance	Comments:
6) Is recipient independent with **eating** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires assistance cutting meat or arranging food ☐ Partial/occasional help ☐ Totally fed (by mouth) ☐ Tube feeding (type and tube location)	Comments:
7) Is recipient independent with **ambulation** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Dependent on device ☐ Requires aid of one person ☐ Requires aid of two people ☐ History of falls (number of falls, and date of last fall)	Comments:
8) Is recipient independent with **transferring** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Hands-on assistance of one person ☐ Hands-on assistance of two people ☐ Requires mechanical device ☐ Bedfast	Comments:
SECTION V - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
1) Is recipient able to prepare **meals** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for meal preparation ☐ Requires supervision or verbal cues ☐ Requires assistance with meal preparation ☐ Requires total meal preparation	Comments:

Name *(last, first)* Medicaid Number

2) Is recipient able to **shop** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for shopping to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with shopping ☐ Unable to participate in shopping	Comments:
3) Is recipient able to perform light **housekeeping** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for light housekeeping duties to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with light housekeeping ☐ Unable to perform any light housekeeping	Comments:
4) Is recipient able to perform heavy **housework** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for heavy housework to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with heavy housework ☐ Unable to perform any heavy housework	Comments:
5) Is recipient able to perform **laundry** tasks ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for laundry to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with laundry tasks ☐ Unable to perform any laundry tasks	Comments:
6)) Is recipient able to plan/arrange for pick-up, delivery, or some means of gaining possession of **medication(s)** and take them independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for medication to be obtained and taken correctly ☐ Requires supervision or verbal cues ☐ Requires assistance with obtaining and taking medication correctly ☐ Unable to obtain medication and take correctly	Comments:
7) Is recipient able to handle **finances** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for someone else to handle finances ☐ Requires supervision or verbal cues ☐ Requires assistance with handling finances ☐ Unable to handle finances	Comments:

Name *(last, first)*	Medicaid Number
8) Is recipient able to use the **telephone** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Requires adaptive device to use telephone ☐ Requires supervision or verbal cues ☐ Requires assistance when using telephone ☐ Unable to use telephone	Comments:
SECTION VI-MENTAL/EMOTIONAL	
1) Does recipient exhibit **behavior** problems ☐Yes ☐No *(If yes, check below all that apply and explain the frequency in comments)* ☐ Disruptive behavior ☐ Agitated behavior ☐ Assaultive behavior ☐ Self-injurious behavior ☐ Self-neglecting behavior	Comments:
2) Is the recipient diagnosed with one of the following: ☐Yes ☐No *(If yes, check below and comment)* ☐ Mental Retardation (Date-of-onset / /) ☐ Developmental Disability (Date-of-onset / /) ☐ Mental Illness (Date-of-onset / /)	Comments:
3) Is recipient **oriented** to person, place, time ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Forgetful ☐ Confused ☐ Unresponsive	Comments:
4) Has recipient experienced a major change or crisis within the past twelve months ☐Yes ☐No *(If yes, describe)*	Description:
5) Is the recipient actively participating in social and/or community activities ☐Yes ☐No *(If yes, describe)*	Description:
6) Is the recipient experiencing any of the following *(For each checked, explain the frequency and details in the comments section)* ☐Difficulty recognizing others ☐Loneliness ☐Sleeping problems ☐Anxiousness ☐Irritability ☐Lack of interest ☐Short-term memory loss ☐Long-term memory loss ☐Hopelessness ☐Suicidal behavior ☐Medication abuse ☐Substance abuse	Comments:

Name *(last, first)* Medicaid Number

SECTION VII-CLINICAL INFORMATION	
1) Is recipient's **vision** adequate *(with or without glasses)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply and comment)* ☐ Difficulty seeing print ☐ Difficulty seeing objects ☐ No useful vision	Comments:
2) Is recipient's **hearing** adequate *(with or without hearing aid)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply, and comment)* ☐ Difficulty with conversation level ☐ Only hears loud sounds ☐ No useful hearing	Comments:
3) Is recipient able to **communicate** needs ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Speaks with difficulty but can be understood ☐ Uses sign language and/or gestures ☐ Inappropriate context ☐ Unable to communicate	Comments:
4) Does recipient maintain an adequate **diet** ☐Yes ☐No *(If no, check all that apply and comment)* ☐ Uses dietary supplements ☐ Requires special diet (low salt, low fat, etc.) ☐ Refuses to eat ☐ Forgets to eat ☐ Tube feeding required *(Explain the brand, amount, and frequency in the comments section)*	Comments:
5) Does recipient require **respiratory** care and/or equipment ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Oxygen therapy (Liters per minute and delivery device) ☐ Nebulizer (Breathing treatments) ☐ Management of respiratory infection ☐ Nasopharyngeal airway ☐ Tracheostomy care ☐ Aspiration precautions ☐ Suctioning ☐ Pulse oximetry ☐ Ventilator (list settings)	Comments:
6) Does recipient have history of a **stroke(s)** ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Residual physical injury(ies) ☐ Swallowing impairments ☐ Functional limitations (Number of limbs affected)	Comments:

Name *(last, first)* Medicaid Number

7) Does recipient's **skin** require additional, specialized care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Requires additional ointments/lotions ☐ Requires simple dressing changes (i.e. band-aids, occlusive dressings) ☐ Requires complex dressing changes (i.e. sterile dressing) ☐ Wounds requiring "packing" and/or measurements ☐ Contagious skin infections ☐ Ostomy care	Comments:
8) Does recipient require routine lab work ☐Yes ☐No *(If yes, what type and how often)*	Comments:
9) Does recipient require specialized genital and/or urinary care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Management of reoccurring urinary tract infection ☐ In-dwelling catheter ☐ Bladder irrigation ☐ In and out catheterization	Comments:
10) Does recipient require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) ☐Yes ☐No *(If yes, explain in the comments section)*	Comments:
11) Does recipient have total or partial paralysis ☐Yes ☐No *(If yes, list limbs affected and comment)*	Comments:
12) Does recipient require assistance with changes in body position ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ To maintain proper body alignment ☐ To manage pain ☐ To prevent further deterioration of muscle/joints/skin	Comments:

13) Does recipient require 24 hour caregiver ☐Yes ☐No

14) Does recipient require respite services ☐Yes ☐No *(If yes, how often)*

15) Does the recipient require intravenous fluids, intravenous medications or intravenous alimentation
☐Yes ☐No *(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)*

☐ **Peripheral IV** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
☐ **Central line** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	

Name *(last, first)* Medicaid Number

16) Drug allergies *(list)*	**17)** Other allergies *(list)*

18) Does the recipient use any medications ☐Yes ☐No *(If yes, list below)*

Name of medication	**Dosage/Frequency/Route**	**Administered by**

Name *(last, first)* Medicaid Number

19) Is any of the following adaptive equipment required *(If needs, explain in the comments)*

Dentures	☐Has	☐Needs	☐N/A
Hearing aid	☐Has	☐Needs	☐N/A
Glasses/lenses	☐Has	☐Needs	☐N/A
Hospital bed	☐Has	☐Needs	☐N/A
Bedpan	☐Has	☐Needs	☐N/A
Elevated toilet seat	☐Has	☐Needs	☐N/A
Bedside commode	☐Has	☐Needs	☐N/A
Prosthesis	☐Has	☐Needs	☐N/A
Ambulation aid	☐Has	☐Needs	☐N/A
Tub seat	☐Has	☐Needs	☐N/A
Lift chair	☐Has	☐Needs	☐N/A
Wheelchair	☐Has	☐Needs	☐N/A
Brace	☐Has	☐Needs	☐N/A
Hoyer lift	☐Has	☐Needs	☐N/A

Comments:

SECTION VIII-ENVIRONMENT INFORMATION

1) Answer the following items relating to the recipient's physical environment *(Comment if necessary)*

Sound dwelling	☐Yes	☐No
Adequate furnishings	☐Yes	☐No
Indoor plumbing	☐Yes	☐No
Running water	☐Yes	☐No
Hot water	☐Yes	☐No
Adequate heating/cooling	☐Yes	☐No
Tub/shower	☐Yes	☐No
Stove	☐Yes	☐No
Refrigerator	☐Yes	☐No
Microwave	☐Yes	☐No
Telephone	☐Yes	☐No
TV/radio	☐Yes	☐No
Washer/dryer	☐Yes	☐No
Adequate lighting	☐Yes	☐No
Adequate locks	☐Yes	☐No
Adequate fire escape	☐Yes	☐No
Smoke alarms	☐Yes	☐No
Insect/rodent free	☐Yes	☐No
Accessible	☐Yes	☐No
Safe environment	☐Yes	☐No
Trash management	☐Yes	☐No

Comments:

2) Provide an inventory of home adaptations **<u>already present</u>** in the recipient's dwelling. *(Such as wheelchair ramp, tub rails, etc.)*

SECTION IX - HOUSEHOLD INFORMATION

1) Does the recipient live alone ☐Yes ☐No

If yes, does the recipient receive any assistance from others ☐Yes ☐No *(Explain)*

Name *(last, first)* Medicaid Number

2) **Household Members** *(Fill in household member info below)*			
a) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

SECTION X-ADDITIONAL SERVICE INFORMATION

1) Has the recipient had any hospital or nursing facility admissions in the past 6 months ☐Yes ☐No
(If yes, please list below)

a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

2) Does the recipient receive services from other agencies *(Example: EPSDT, Aging programs, Meals on Wheels, Community action, etc.)* ☐Yes ☐No
(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care)

a-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units

Name *(last, first)* Medicaid Number

c-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units

3) Is the recipient receiving traditional home health services ☐Yes ☐No *(If yes, list below all traditional home health services that are covered by Medicare/Medicaid/Third Party Insurance)*		Anticipated home health discharge date
a-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay
b-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay
c-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay

4) Summary for ***(check only one)*** ☐ Certification ☐ Amendment/Modification

Signature: Date / /

5a) Team performing assessment or reassessment:

Signature:	Title:	Date / /
Signature:	Title:	Date / /

5b) ADHC RN (If ADHC services are being requested)

☐ ***I agree with this assessment*** ☐ I disagree with this assessment Signature:	Title:	Date / /

6) PRO Signature:	Date / /	Approval dates From: / / To: / /

The MAP 351A Form
(Revised 4/23/04)

The MAP 351A is to be used by Home and Community Based Waiver, Adult Day Health Care, Model Waiver II, Homecare Waiver, and Personal Care Assistance Waiver providers. The MAP 351A is designed to be a complete and thorough assessment of the patient that:

1. Can be used by the Peer Review Organization (PRO) to determine and validate the level of care and the appropriateness of services to be prior-authorized; and

2. Assists the providers in developing an appropriate plan of care.

General Information Regarding the MAP 351A

- The MAP 351A is to be used by waiver providers as an assessment document and shall be completed by the assessment team at each certification, re-certification, and reapplication. Once completed, the MAP 351A is to be forwarded to the PRO for level of care validation and supporting documentation in determining the appropriateness of services to be prior-authorized.

- Throughout the form there are "Comments sections" to provide the PRO with a better understanding of the applicant/recipient's difficulty. These entries serve as supporting documentation.

- Provide the applicant's name (last, first) and Medicaid Identification Number (Social Security number for individuals whose eligibility is pending) in the appropriate spaces at the top of each page.

- Completion and submittal of pages one (1) through nine (9) are **not** necessary when requesting a modification/amendment. Complete and submit MAP 9, MAP 10, and items 4-5 on page ten (10) for a modification/amendment.

- It is imperative that all questions be answered in their entirety. Failure to complete the form clearly and accurately will result in the return of the form to the waiver provider.

Section Instructions for Completing the MAP 351A

Section I – Recipient Demographics

This section compiles the recipient's demographics. Answer each question, **do not** leave blank or enter "N/A".

Name

Enter the applicant/recipient's full name (Last, First, Middle).

Date of Birth

Enter the applicant/recipient's date of birth (MM/DD/YYYY).

Medicaid Number

Enter the ten (10) digit Kentucky Medical Assistance number found on the recipient's Medicaid identification card. If the applicant's Medicaid eligibility has not yet been determined, enter the individual's social security number.

Street Address

Enter the street address where the applicant/recipient resides.

County Code

Enter the three (3) digit county code of the applicant/recipient's residence. For convenience, a listing of the county codes has been enclosed.

Sex

Check the box corresponding with the applicant/recipient's gender.

Marital Status

Check the box corresponding with the applicant/recipient's current marital status.

City, State and zip code

Enter the city, state and zip code where the applicant/recipient resides.

Emergency Contact (name)

Enter the name of the person whom the recipient or his legal representative designates as the emergency contact for the applicant/recipient.

Emergency Contact (phone number)

Enter the phone number of the individual designated as the applicant/recipient's emergency contact

Recipient phone number

Enter the phone number of the applicant/recipient or a number where he/she may be contacted.

Is recipient able to read and write

Check the box corresponding with the appropriate answer.

Recipient's height

Enter the applicant/recipient's height in feet and inches.

Recipient's weight

Enter the applicant/recipient's weight in pounds.

Section II – Recipient Waiver Eligibility

This section compiles information regarding the applicant/recipient's waiver eligibility. Answer each question in this section, **do not** leave blank or enter "N/A".

Type of program applied for (check one)

Check the box that matches the waiver program for which the applicant/recipient is applying.

Type of Application

Check the box corresponding with the appropriate type of application for the completion of this MAP 351A.

"Certification" refers to the applicant/recipient's application into the waiver program.

"Re-certification" refers to the recertification of a waiver recipient to obtain approval for continuing or on-going care.

Recipient admitted from (check one)

Check the appropriate box that accurately reflects the applicant/recipient's current situation. If "other" is checked, please define.

Certification period

Enter the beginning and ending dates (MM/DD/YYYY) of the certification or recertification period.

Has applicant/recipient's freedom of choice been explained and verified by a signature on the MAP-350 Form

Check the box corresponding with the accurate answer.

Has recipient been informed of the process to make a complaint

The applicant/recipient must be informed of the proper procedures for filing complaints. Check the box matching the accurate answer.

Home and Community Based Waiver/Adult Day Health Care Recipients and Model Waiver II recipients may file a complaint by contacting the Commonwealth of Kentucky, Office for Inspector General at 1-800-635-6290.

Homecare Waiver and Personal Care Assistance Waiver recipients may file a complaint by contacting the Commonwealth of Kentucky, Office of Aging Services at (502) 564-6930.

Physician's name

Enter the full name of the applicant/recipient's physician.

Physician's license number

Enter the five (5) digit license number of the applicant/recipient's physician.

Physician's phone number

Enter the phone number of the applicant/recipient's physician.

Enter recipient diagnosis(es)

Enter the recipient's medical/mental diagnosis(es) information requested in the order listed. Enter "none" in "secondary" and "others" only if there is not more than one diagnosis for the applicant/recipient.

Section III – Provider Information

This section compiles the waiver provider's information. Answer each question, **do not** leave blank or enter "N/A"

Provider name

Enter the name of the waiver provider.

Provider number

Enter the eight (8) digit provider number of the waiver provider entered in the "Provider name" entry.

Provider phone number

Enter the waiver provider's phone number.

Street Address

Enter the waiver provider's street address.

City, state and zip code

Enter the waiver provider's city, state and zip code.

Provider contact person

Enter the name of an individual with the waiver provider who may be contacted if there are any questions regarding information contained on the MAP 351A.

NOTE: The designated individual must be familiar with the applicant/recipient and the information contained on the MAP 351A.

Section IV – Activities of Daily Living

This section compiles information regarding the applicant/recipient's ability to participate in daily living activities. There are eight (8) questions in this section. Read each question and check the appropriate answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

Example: Using the first question, "Is recipient able to dress independently" the assessment team determines that the individual is unable to dress himself and the team marks the answer "no". Upon reviewing the supporting statements and evaluating the individual, the team then marks "Requires total assistance". Since the team answered "no" to the question, details must be provided in the "Comments" section. The assessment teams writes "Due to recent stroke, patient is unable to raise arms to dress self --- requires total assistance" as supporting documentation.

1. Dress independently

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Groom independently

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Independent with bed mobility

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Independent with bathing

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Independent with toileting

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Independent with eating

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Independent with ambulation

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent with transferring

Check yes or no. If yes, proceed to Section V. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section V – Instrumental Activities of Daily Living

This section compiles information regarding the applicant/recipient's ability to perform complex tasks essential in community living. There are eight (8) questions in this section. Read each question and check the appropriate "yes" or "no" answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

Example: Question #6, "Is recipient able to obtain and take medication independently", the assessment team determines that the applicant/recipient is unable to do so and marks "no" on the form. Upon reviewing the supporting statements contained on the form, the team marks "Arranges for medication to be obtained and taken correctly". The assessment team writes, "The patient's daughter obtains medication on a monthly basis and arranges it in a medi-planner for her mother each week" as supporting documentation.

1. Meal preparation

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statement and provide detailed information in the "Comments" section.

2. Independent shopping

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Light housekeeping

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Heavy housekeeping

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Laundry tasks

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Obtaining and taking medication independently

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Handling finances independently

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent usage of telephone

Check yes or no. If yes, proceed to Section VI. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section VI – Mental/Emotional

This section compiles information regarding the applicant/recipient's mental and emotional health. There are six (6) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

1. Behavior problems

   Check yes or no. If no, proceed to question #2. If yes, check the applicable, supporting statements and provide detailed information along with the frequency in the "Comments" section.

2. Recipient mental diagnosis

   Check yes or no. If no, proceed to question #3. If yes, check the applicable diagnosis and enter the date-of-onset. Provide detailed information in the "Comments" section.

3. Recipient orientation to person, place and time

   Check yes or no. If yes, proceed to question #4. If no, check the applicable statements and provide detailed information in the "Comments" section.

4. Major change or crisis

   Check yes or no. If no, proceed to question #5. If yes, provide detailed information in the "Description" section.

5. Social and/or community activities

   Check yes or no. If no, proceed to question #6. If yes, provide detailed information in the "Description" section.

6. Recipient history

   Check the applicable, supporting statements and provide detailed information along with the frequency in the "Comments" section.

Section VII – Clinical Information

This section compiles information regarding the applicant/recipient's clinical background. There are nineteen (19) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

1. Adequate vision

   Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Adequate hearing

   Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Communicating needs

   Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Adequate diet

   Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Tube feeding require" is checked, provide the brand, amount, and frequency in the "Comments" section.

5. Assistance with breathing

   Check yes or no. If no, proceed to question #6. If yes, check the applicable, supporting statements and provide as much detailed information as possible in the "Comments" section. The information in the "Comments" section is to include the status of the applicant/recipient's respiratory condition (i.e. stable, declining, weaning). If "Oxygen therapy" is checked, provide the liters per minute and deliver device in the "Comments" section. If "Ventilator" is checked list the settings in the "Comments" section.

6. History of stroke(s)

Check yes or no. If no, proceed to question #7. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Functional limitations" is checked, provide number of limbs affected in the "Comments" section.

7. Skin care

Check yes or no. If no, proceed to question #8. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Routine lab work

Check yes or no. If no, proceed to question #9. If yes, provide details, including the type and frequency, in the "Comments" section.

9. Genital and/or urinary care

Check yes or no. If no, proceed to question #10. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

10. Physician ordered vital sign evaluation

This question refers to **physician** ordered vital sign evaluation (i.e. orthostatic blood pressure). Check yes or no. If no, proceed to question #11. If yes, provide detailed information in the "Comments" section including type of evaluation order by the physician and frequency.

11. Total or partial paralysis

Check yes or no. If no, proceed to question #12. If yes, provide detailed information in the "Comments" section including the limbs affected.

12. Changes in body position

Check yes or no. If no, proceed to question #13. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

13. 24 hour caregiver

Check yes or no and proceed to question #14.

14. Respite services

Check yes or no. If no, proceed to question #15. If yes, provide the frequency the service is required.

15. Intravenous fluids, IV medications or IV alimentation

Check yes or no. If no, proceed to question #16. If yes, check the supporting statements and provide the requested information, including the solution, location, amount, rate, frequency and prescribing physician.

16. Drug allergies

List any known drug allergies and type of reaction, if known (i.e. penicillin – hives). If there are no known allergies, enter "None", "NKDA" or "NKA".

17. Other allergies

List any other known allergies and type of reaction, if known (i.e. shellfish – respiratory distress or medical/surgical tape – blisters). If there are no other known allergies, enter "None" or "NKA".

18. Medications

Check yes or no. If no, proceed to question #19. If yes, list each medication and provide the name of the medication, dosage/frequency/route and the name of the person who administers the medication (i.e. self, son, caregiver, RN, etc.). If more space is required, attach additional pages as needed.

19. Adaptive equipment

Check has, needs or N/A for each item listed. For items that are checked needs, provide details in the "Comments" section.

Section VIII – Environmental Information

This section compiles information regarding the applicant/recipient's physical environment. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Physical environment

   Check yes or no for each item listed. If no, provide detailed information in the "Comments" section when appropriate. For example, the item "Accessible" is checked "no". An appropriate comment may be "Patient's doorways are not wide enough to accommodate his wheelchair."

2. Inventory of home adaptations

   List and provide detailed information regarding any home adaptations already present in the applicant/recipient's home.

Section IX – Household Information

This section compiles information regarding the applicant/recipient's household. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Recipient residing alone

   Check yes or no. If no, proceed to question #2. If yes, check the appropriate answer regarding assistance from others. If the applicant/recipient is receiving assistance from others, provide detailed information.

2. Household members

   Provide the name, relationship and age of the applicant/recipient's household member(s). Check yes or no if the individual is functionally able to provide care. If no, provide a detailed explanation in the "Comments" section. If yes, provide detailed information including the type of care provided and frequency in the "Comments" section.

Section X – Additional Service Information

This section compiles information regarding any additional services the applicant/recipient is receiving. There are five (5) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Hospital or nursing facility admissions

Check yes or no. If no, proceed to question #2. If yes, provide the facility name, facility address, reason for admission, admission date and discharge date in the appropriate spaces.

2. Services from other agencies

Check yes or no. If no, proceed to question #3. If yes, provide the type of service, agency/worker name, agency/worker phone number, agency address, frequency service provided and number of units (if applicable) in the appropriate spaces.

3. Traditional home health services

Check yes or no. If no, proceed to question #4. If yes, provide the anticipated home health discharge date, type of service, visits (indicate per week or per month) and type of coverage (indicate Medicare, Medicaid, private insurance and/or private pay) in the appropriate spaces.

4. Summary

Check certification or amendment/modification and summarize the applicant/recipient's assessment in the space provided. It must be signed and dated by the member(s) of the assessment team who completed this section.

5.(a) Assessment team signatures

Both members of the assessment/reassessment team must sign, provide their titles and date the MAP 351A form in this section.

5.(b) RN ADHC Agreement

Check agree or disagree. If the RN at the ADHC disagrees with the assessment, documentation supporting disagreement shall be attached to the MAP 351A.

6. PRO signature

This area is reserved for use by the Peer Review Organization. **Do not** complete this area.